ST. BARTHOLOMEW'S HOSPITAL JOURNAL.

WAR MEMORIAL NUMBER.

SEEN THROUGH THE MAIN ARCH—THE CEREMONY IN THE SQUARE. *Daily Mirror.*

St. Bartholomew's Hospital Journal.

"Æquam memento rebus in arduis
Servare mentem."
—*Horace*, Book ii, Ode iii.

VOL. XXXIII.—No. 12.] SEPTEMBER 1ST, 1926. PRICE NINEPENCE.

Finis coronat opus. Eight years after the end of the War our Memorial has been unveiled. To none more than to the relations of those we commemorate will the full slow length of these years have been brought home. Even the least concerned can measure them with a calculation that they represent a period longer than the full course of medical training, which is in itself a lifetime. Yet what will eight years be to us as a body who have lived 800 years in the shadow of the Fountain and before it ever was? The memory of the men themselves is very little blurred. In the perspective that comes with an increase of intervening atmosphere their characters stand out the more. When a portrait is hung and treasured, the details and the lights that make up its character to those who live intimately with it are jealously kept free from the dust and cracks which would obliterate it were it like those friendless daubs discarded in the lumber-room. But it is the thoughts men thought in those days we forget—the suspense, the longing for peace—that have their surprising counterpart in the present struggle over a matter of working hours, showing an independence which is the usual legacy of freedom to a victorious nation.

Few will fail to agree that no finer or more permanent form could have been chosen to express our feelings for those who were killed—an archway of fine proportion (not ornate) over the way they went so often during life, and the strategic key to the Hospital. On one side of it the outside world with its cars, its crowds and its flower-sellers, and on the other the Republic of Rahere, with its mysterious and tireless machinery.

THE WAR MEMORIAL.

THE ceremony of unveiling and dedication of the memorial to those students of St. Bartholomew's Hospital who gave their lives in the Great War took place on July 8th, 1926. The ceremony was performed by H.R.H. The Prince of Wales, K.G., the President of the Hospital, who was received at King Henry VIII Gate by the Treasurer, Lord Stanmore, the Almoners, Dr. Morley Fletcher the Senior Physician, Sir Holburt Waring the Senior Surgeon, the Matron and Mr. Hayes.

Topical Press Agency.

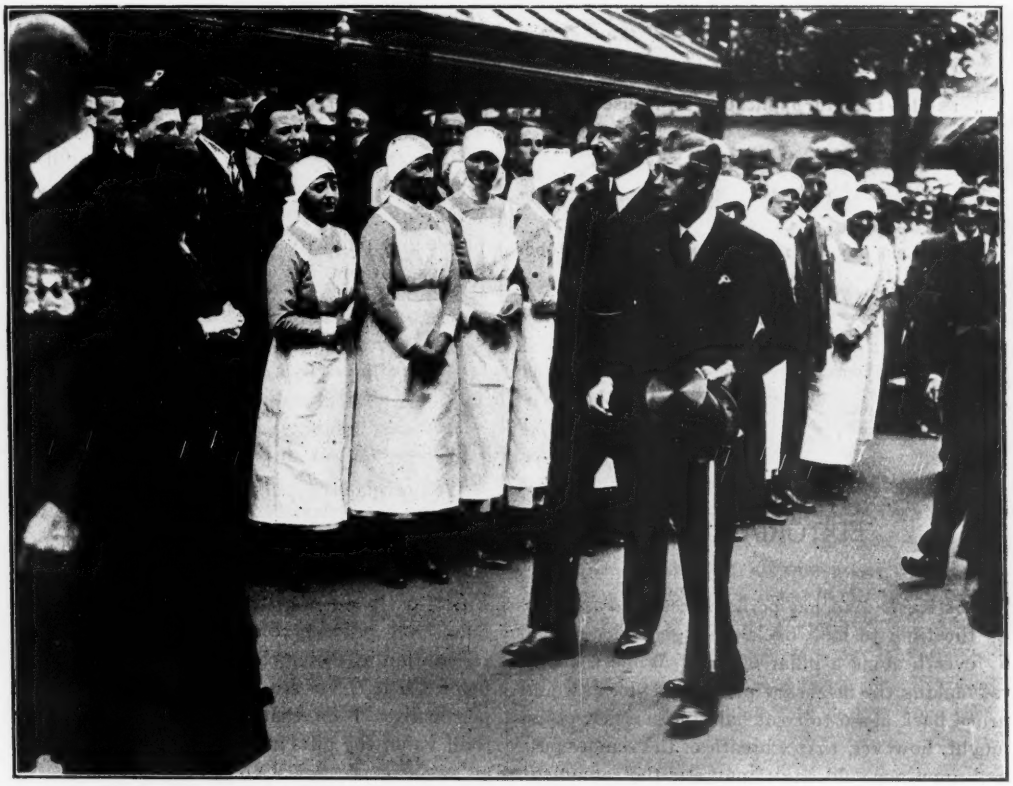
The Prince inspected the Guard of Honour, which was provided by the Honourable Artillery Company under Capt. W. A. Stone, M.C. A further Guard of Honour, consisting of some 60 Hospital porters, most of whom were ex-service men, was also inspected.

The Prince was then escorted to the Treasurer's office by Lord Stanmore, who introduced to him the members of the War Memorial Committee, namely, Sir Anthony Bowlby, Bt., K.C.B., K.C.M.G. (the Chairman), Sir Archibald Garrod, K.C.M.G., Sir Charles Gordon-Watson, K.B.E., Dr. Henry Burroughes, Mr. G. B. Tait and Mr. Girling Ball (Hon. Secretary). The Chaplain-General of the Forces, the Rev. H. C. E. Jarvis, C.M.G., M.C., D.D., and the Hospitaller, the Rev. J. L. Douglas, were also introduced. A procession was then formed to conduct the Prince to a daïs which had been placed in front of the War Memorial in the midst of a gathering of the relatives and friends of those who had lost their lives, Governors of the Hospital, the Medical and Surgical Staff, a large gathering of subscribers, students and nurses of the Hospital. The Lord Mayor and Sheriffs were present, as also were the Directors-General of the Navy, Army and Air Force, in the persons of Surgeon Vice-Admiral Sir J. Chambers, Major-General Sir Matthew Fell, and Air Vice-Marshal David Munro.

A short service conducted by the Chaplain-General was opened with the singing of the hymn, "O God, our help in ages past." The lesson was read by the Hospitaller, after which there was a brief silence. Sir Anthony Bowlby then presented to the Prince a volume which had been compiled by Mr. Girling Ball, containing the records of the 112 men who gave their lives, with the request that he would be pleased to unveil the Memorial. This he proceeded to carry out, saying—"To the Glory of God and in honoured memory of the students of St. Bartholomew's Hospital who gave their lives in the Great War I unveil this memorial." This was followed by a dedication prayer rendered by the Chaplain-General, the Last Post and Réveillé, given by the buglers of the Honourable Artillery Company, and the National Anthem.

The Prince then inspected the Memorial, which is placed in the archway under the Great Hall between the Renter's and the Steward's office. The old vaulted plaster roof has been replaced by a similar construction in Portland stone, and on the panels on each side of the doorways are inscribed the names of the men, cut in Portland stone. The names are inscribed in alphabetical order and without distinction of rank. The name of Capt. Leslie Green, who had been awarded the Victoria Cross, was especially pointed out to the Prince. The Members of the Council of the Students' Union were then introduced to His Royal Highness by Lord Stanmore.

On his departure the Prince walked round the Square of the Hospital, where he was enthusiastically received by the nurses and students and friends present.



Topical Press Agency.

Laurel wreaths provided by the Governors of the Hospital, the Council of the Medical College, the Students' Union and the League of St. Bartholomew's Hospital Nurses were placed against the four panels.

A copy of the volume containing the records of those who gave their lives has been inscribed in vellum and will be placed among the Hospital records. A copy similar to that presented to the Prince of Wales will be sent to the relatives of these men. It may be mentioned that the Secretary is not in possession of the addresses of all of these, and would be grateful if those who do not receive a copy will communicate at once with him.

CALENDAR.

Fri., Sept. 3.—Dr. Morley Fletcher and Sir Holburt Waring on duty.

Mon., „ 6.—Post-Graduate Vacation Course starts.

Tues., „ 7.—Sir Percival Hartley and Mr. McAdam Eccles on duty.

Fri., „ 10.—Sir Thomas Horder and Mr. L. B. Rawling on duty.

Tues., „ 14.—Dr. Langdon Brown and Sir C. Gordon-Watson on duty.

Fri., „ 17.—Prof. Fraser and Prof. Gask on duty.

Sat., „ 18.—**Last day for application for House Appointments.**

Post-Graduate Vacation Course ends.

Tues., „ 21.—Dr. Morley Fletcher and Sir Holburt Waring on duty.

Last day for receiving matter for October issue of the Journal.

Fri., „ 24.—Sir Percival Hartley and Mr. McAdam Eccles on duty.

Tues., „ 28.—Sir Thomas Horder and Mr. L. B. Rawling on duty.

EDITORIAL.

A MEDICAL man has perhaps less than anybody the time to look back. No good doctor will ever become a pillar of salt. While the conjuror was making the necessary passes, his victim would have turned back again to treat half a dozen new cases. It is thought, however, that a breath of the remote past condensed upon our cold pages may stir the somnolent memories of old Bart.'s men, to whom this number is largely addressed, and make them give us a thought in the stilly hours. For the principles and practice of medicine the meanest will freely own indebtedness, but it will take a great man to realize that a tumbledown chair in the A.R., a bedroom in R.S.Q., round which the clattering carnival of Giltspur Street rages in the small hours, or perhaps a culminating and apparently arbitrary disappointment over a House job are all examples of fond parenthood.

* * *

A great addition to the Hospital and a formidable rival to our underground Dining-room is the new Out-patients' Bar and Canteen combination, where mixtures absolutely guaranteed to contain no rhubarb or gentian are dispensed lavishly at unusual prices. The effect on the number of patients has been extraordinary already.

* * *

We call our readers' attention to the following letter:

DEAR MR. EDITOR,—You are, I believe, in the next issue of the JOURNAL giving an account of the ceremony of unveiling the War Memorial. Now that it is completed I am sorry to say there will not be sufficient money subscribed to pay for it entirely. I feel sure that there must be a number of people who have waited until the Memorial should be finished before subscribing. I have had many letters from those who have seen it, stating that they regard it as a beautiful memorial, and I feel sure that there are many Bart.'s men who would like to add their quota. Will you, therefore, please give publicity to the fact that we are still in need of subscriptions.

Yours truly,
W. GIRLING BALL,
Hon. Sec. S.B.H. War Memorial Committee.

* * *

We are glad to publish the following from an old friend:

DEAR MR. EDITOR,—Will you, through the JOURNAL, convey my thanks to the members of the Senior Surgical Firm—past and present—who contributed towards the handsome gifts I received on the occasion of my resignation as Sister of Pitcairn Ward. I was unable, before I left, to see them all and to thank them personally. I do thank them all most heartily and shall value the gifts immensely.

Yours sincerely,
EMILY K. MOORE.
PITCAIRN WARD;
August 5th, 1926.

* * *

We congratulate Dr. H. Harold Scott, M.D., F.R.C.P., on being elected Lecturer in Tropical Medicine at Westminster Hospital Medical School; and Mr. J. M. Duncan Scott, who has been made Professor of Physiology, University of Saskatchewan, Saskatoon, Canada.

* * *

We remind men who intend to apply for House Appointments that they must leave their applications with the Warden on or before Saturday, September 18th.

OBSERVATIONS ON THE TOXINS OF THE HÆMOLYTIC STREPTOCOCCI.

DURING the latter part of June we carried out some very interesting observations on the skin reactions to the toxins produced by hæmolytic streptococci. They were mass experiments done on students and others volunteering for the tests, and as the first part of the work has been practically completed, it may be of interest to record the results.

It was not formerly supposed that streptococci formed filterable toxins. This was chiefly because the products obtained had been tested only on animals, and it is true that filtered broth cultures, even of virulent hæmolytic streptococci, produce very little effect upon laboratory animals, usually failing to kill a mouse. But when the projects are injected intradermally into the human skin a definite reaction is seen in susceptible persons, as in the now well-known Dick test. The credit of demonstrating the value of this test belongs to the Americans. It has been shown, notably by the Dicks at Chicago and by Dochez at New York, that the special strain of streptococcus found in the throat of scarlet fever produces a toxin which is effective on the human skin in a dilution of 1 in 1000, or even higher; and that it is possible to immunize horses against it, which then yield an antitoxic serum of high value in the treatment of scarlet fever. All this has been amply confirmed in this country by O'Brien, of the Wellcome Laboratories at Beckenham.

The suggestion is that this special race of hæmolytic streptococcus is actually the primary cause of scarlet fever, and that this disease is essentially a toxic one, the main symptoms being due to absorption of the toxin from the local lesions in the throat, while in some severe cases a true streptococcal septicæmia arises. There are still some pathologists—and I must confess myself one of them—who, while admitting the dominant *rôle* of the streptococcus in scarlet fever and fully supporting the toxic nature of the disease, are not yet wholly convinced that there may not be some more primary cause, perhaps of the nature of a filter-passing virus, behind the streptococcus; but we may well be wrong. At all events the beneficial influence of the antitoxic serum prepared from the scarlatinal streptococcus seems beyond question.

Now it will be universally admitted that we do not at present possess any therapeutic agent which is of similar value in the treatment of the many dangerous diseases, such as erysipelas, puerperal fever, cellulitis and lymphangitis, which seem unquestionably due to the coccus we call "*Streptococcus pyogenes*"—an organism so common, so multifarious in its activities and so deadly that it may well rank amongst the worst enemies of the human race. It is notorious that the various sera hitherto prepared against this streptococcus have not proved a conspicuous success, but they have been anti-bacterial, not antitoxic, sera.

May it not be that if we had a potent serum prepared with the *toxins* of this organism, we might achieve the success so far denied? The attempt is at least worth making, for the reward would be of such enormous value. Every surgeon who has watched a severe case of streptococcal infection must have been struck by the symptoms of profound poisoning exhibited by the patient—a poisoning with which he was powerless to cope.

The problem has been to produce a sufficiently potent toxin from *Streptococcus pyogenes*. Birkhaug, in America, has produced a toxin from erysipelatous strains, and has prepared an antitoxic serum which he claims to possess specific value in cases of erysipelas. The serum has not been tested in this country. It happened that last autumn one of our nurses—Nurse Shilling—ran a splinter under her thumbnail from a form in the Surgery. In eighteen hours she was dangerously ill with lymphangitis and a temperature of over 104° F., but with suitable treatment she recovered. Her streptococcus proved an unusually virulent one. After passage through three mice I found that it killed a mouse when intraperitoneally injected in a dose as small as one two-millionth of a c.c. of a blood broth culture. I gave the strain to Dr. Okell, of Messrs. Burroughs & Wellcome's staff at Beckenham, and he was able to prepare from it a fairly potent toxin, about one quarter of the strength of ordinary Dick toxin—that is to say, active on the human skin in a dilution of 1 in 250.

Last autumn, too, occurred the lamented death of Dr. Swann, at Cambridge, from streptococcal septicæmia. The coccus recovered from this case, when tested at the Wellcome Laboratories, also yielded a toxic filtrate, though this appeared to be weaker than that of the Shilling coccus.

Finally, a small supply of the erysipelas toxin made in America was available by the kindness of Dr. Birkhaug.

As these toxins can only be tested upon the human skin, and as the test causes little or no inconvenience, an appeal was made to the students of St. Bartholomew's to come forward as volunteers in as large numbers as possible in order that the toxins might be tested on an adequate scale.

We had four streptococcal toxins for the experiment, three of them prepared at the Wellcome Laboratories by Dr. O'Brien and his colleagues, warranted sterile and sent us in different strengths. The first problem was to titrate the strengths of the different toxins. A uniform skin dose of 0·2 c.c. was employed throughout.

It was already known that the proper dose of the Dick toxin was 0·2 c.c. of a 1 in 1000 dilution—that is to say, that this amount would produce a definite reaction in the great majority of susceptible persons. The strength of the Shilling toxin was believed to be about a quarter of that of the Dick toxin, so that a dilution of 1 in 250 ought to prove the correct dose. To test this 18 men were given the usual dose of 1 in 1000 and 1 in 250 dilutions. Only 8 men reacted to the weaker dilution, while every man reacted well to the stronger one, though in a more extended later test negatives were found. Clearly 1 in 250 was a suitable dilution to use.

The Swann toxin was tested on 20 men. Preliminary tests having shown that the toxin was a weak one, it was used in dilutions of 1 in 100 and 1 in 50. With these dilutions "pseudo-reactions" occurred in almost every case, largely masking the true reactions. It must here be explained that many people are sensitive to some unknown substance in a filtered bacterial culture other than the true toxin, perhaps derived from the broth, perhaps from some constituent of the bacterial body. This substance resists boiling, whereas the true toxins are destroyed by boiling. This is why, in intradermal tests of the sort under consideration, control inoculations with boiled toxin have always to be done in the opposite arm. The stronger the toxin, the more dilute is the solution which can be employed and the less obtrusive are pseudo-reactions. With the 1 in 1000 Dick toxin they were scarcely seen; with the 1 in 250 Shilling toxin they occurred in a few cases, but did not obscure the result. But with the Swann toxin at a dilution of 1 in 50 they were universal, and it was only possible to judge whether a man was susceptible or not by the relative sizes of the reactions in the inoculated and in the control arm. On this basis it appeared that 50 per cent. of the men tested were positive, but it was felt that until a more potent toxin could be prepared from this streptococcus it was useless to employ it in further tests.

The erysipelas toxin also proved a weak one. Thirteen men were first tested with dilutions of 1 in 1000 and 1 in 250. Two were negative and 11 gave weak positive reactions. In the final test, in which three toxins were compared, it was decided to use a dilution of 1 in 100, and in this strength the pseudo-reactions were numerous, but not sufficient to obscure the readings altogether.

Having thus determined the suitable dilutions in which the toxins should be used in order to obtain comparable results, we proceeded to carry out the test for comparing susceptibility to three toxins simultaneously. This was the main test for which the preceding ones had been preparatory: its object was to ascertain whether the three toxins were the same or different. If certain men reacted differently to the different toxins the fact would suggest that the toxins were not the same.

The test was carried out as follows: The Swann toxin was not employed, for reasons already given. The Dick toxin was used in a dilution of 1 in 1000, the Shilling toxin in one of 1 in 250, and the erysipelas toxin in one of 1 in 100. Forty-eight volunteers came forward for the test, and each received the test dose of each toxin in the left arm and the corresponding dose of boiled toxin in the right arm. The results were read twenty-four hours later. In the case of pseudo-reactions, a man showing equal reactions in the two arms was recorded as negative, but where the reaction in the test arm greatly exceeded that in the control arm the result was regarded as positive. The results may be shown in tabular form:

No. of men.	Dick toxin.	Shilling toxin.	Erysipelas toxin.
8	0	0	0
6	+	0	0
13	+	+	0
2	+	0	+
1	0	+	0
18	+	+	+

It is seen that while the majority of men (26 out of 48) were either positive to all three toxins or negative to all, no less than 22 men showed differences in their response. The evidence was, of course, clearest in the case of men giving no pseudo-reactions; here there was one giving a clear + + 0 and another with a clear + 0 +; we should like to re-test such crucial instances in order to confirm the results.

Hearty thanks are due to those who so kindly volunteered for these experiments, and it will be a satisfaction to them to know that the information obtained is of considerable value. No experiment of this kind and on such a scale has hitherto, so far as we know, been carried out. The results definitely suggest, even if they do not finally prove, that different races of hæmolytic streptococci, already known to differ in such serological properties as agglutination, form also different toxins. Such information is the first step towards the preparation of antitoxic sera for the different races of streptococci.

The matter, however, requires more conclusive proof, and this we hope to carry out forthwith. Horses have been immunized at the Wellcome Laboratories against all these toxins; the antitoxic sera are available, but their potencies, except in the case of the scarlatinal strain, have not yet been titrated. This can only be done on the normal human skin. It has to be ascertained what dose of the serum will prevent the skin reaction known to be produced by a suitable dose of the corresponding toxin. When this has been determined comes the crucial set of experiments, namely,

the attempted "cross-blockings" of the several toxic reactions by heterologous sera. Should it be shown that one cannot prevent, say, the Dick reaction with an anti-Shilling serum or the Shilling reaction with an anti-erysipelas serum, although the reaction can be blocked by the homologous antiserum, the proof as to the differences between the toxins will be completed.

Amongst the hundred men who have already volunteered for the toxin tests suitable material is to be found for the further observations required. Only men free from pseudo-reactions are suitable, and only those giving positive reactions are of any use, but the tests already carried out indicate that some 37 men out of the hundred would form an excellent field for the antitoxin tests. They already know how small is the inconvenience attending the skin reactions, and it is earnestly hoped that they will be willing, when asked, to come forward once more; for the importance of these observations can hardly be over-estimated. Should it finally be proved that the toxins in question are distinct from one another, we have at once in sight the prospect of making appropriate anti-sera, which may be used for neutralizing at all events those toxic phenomena of the different streptococcal infections which constitute their chief danger.

FREDERICK ANDREWES.

A LECTURE ON THE NERVOUS PRIMIGRAVIDA.

(As yet undelivered.)

GENTLEMEN,—I should like to point out to you the essential difference between hospital practice and private practice, namely, that in the one you have no responsibility, in the other you have it all. Realization of this in midwifery comes pretty quickly to you. Confronted in hospital by some difficulty hitherto unfamiliar, you may very easily refer it to your chief, whose opinion and advice are final and comforting, and you may then retire to bed with a quiet mind. How different it is in private! It may be that you cannot get a second opinion just when you most need it, and over and over again when you have one it proves to be of no practical use. The consultant will arrive and will agree with your diagnosis, he will add some footling detail to the treatment, assure the relatives that you are a very good man, and having informed you that he is now going away for the week-end, he will pocket his fee and leave you to it. Three hours later, some gigantic text-book in the meantime increasing your anxiety and uncertainty, you will wish with all your heart and soul that you really knew something about your business. The man who undertakes midwifery accepts a responsibility which cannot be shifted to other shoulders.

Your better-class patient will probably consult you soon after missing her first or second period, and you should take that opportunity of instructing her in the management of her health during pregnancy. Tell her when to expect fœtal movements, when the confinement is likely to occur, and warn her of those symptoms which must be immediately reported to you. She will want to know whether she may have connection with her husband or not, and whether it will be best for her to be confined in her own house, or in some institution or nursing-home. As to this last, you must bear in mind the possibility of some unforseen complication, and if she be a primigravida, and the question of expense does not arise, advise in favour of a nursing-home without hesitation. You will thus make sure that ample nursing assistance is available if required at any operation, and you may with good luck be able, at any rate in part, to isolate your patient from her female relatives. You should remember that a large number of young women understand nothing whatever about child-bearing, that their ideas are fixed on those awe-inspiring words, "chloroform and instruments," and that they are genuinely afraid of the unknown. Moreover, as like as not, they have been made acquainted with some of those fantastic superstitions which yet linger in old wives' tales, and which will be related to you for the first time when you call to vaccinate the baby. Often such patients are not good at bearing pain, and their capacity in this respect seems to be inversely proportional to their intellectual attainments. It is a great mistake to label these patients neurotic. They are, in truth, very sensitive, and a fine sense of pain is no more neurotic than a fine taste for port. Finally, never tell a patient that having a baby is like having her bowels opened; the lie is too colossal to inspire confidence.

The best obstetric aphorism that ever I heard came from an old country practitioner, who, in reply to a question, remarked that "interesting midder's ——— awful!" The function of an ante-natal clinic is to eliminate that interest. When in the course of an examination in the later months of pregnancy you discover some important abnormality, let us say a breech presentation, you should neither let your face fall into you boots and say, "You know, Mrs. X—, you're all wrong inside," nor should you indulge in a prolonged, vigorous and possibly unsuccessful manipulation without explaining what it is all about. Try to give the patient credit for some glimmer of intelligence. It is usually best to say that the baby's head is upwards

instead of downwards, that in nine cases out of ten the position corrects itself, but that if at your next visit nothing has happened you will put it right. By efficient ante-natal supervision you ought to be able to correct almost all the abnormal presentations, and to sort out those cases in which, by reason of disproportion between the head and the brim, there is likely to be abnormal difficulty. Similarly the toxæmias, an occasional case of placenta prævia, the multiple pregnancies and those complicated by heart disease or tuberculosis can be placed under the best possible conditions for confinement. Anticipation and prevention of difficulty in labour is the purpose of modern methods, but the business should not be overdone. There is no need to be unduly apprehensive, and it is fortunate that in one's own obstetric development that rather morbid stage, characterized by an unreasoning fear that the eagerly awaited infant almost certainly has a cleft palate and club feet, soon passes off. Parenthetically, why do parents always desire to name such a child after the doctor?

At your last visit, which should be a day or two before the confinement is due, make certain that everything you are likely to want or have asked to be provided is at hand. In the early stages of labour, do nothing. If you proceed to give every patient a hypodermic injection of morphia and hyoscine, as is sometimes advised, you will have many "lingering labours," and will be often under the necessity of diagnosing "rigid os," or some such myth to account for them. When you have had some practice, you will be able to judge of the progress of the descent of the head by abdomiual palpation alone, and when no longer to be felt by this method you will observe it begin to distend the perinæum. At this time the pains are very sharp, and not infrequently the patient vomits. Now is the time to permit the patient to pull on the foot of the bed—if she can. If allowed too soon, apart from being quite useless and most discouraging, this procedure may possibly nip the anterior lip of the cervix between the head and the symphysis, and at any time there is no better way of exhausting your patient's strength. Withhold chloroform as long as is reasonable; if you begin to give it before the head is on the perinæum, you may be tolerably certain it will never get there. Obstetrically speaking, vaginal examination is practically never necessary, but if you must make one, do it thoroughly, and find out everything you want to know beyond the possibility of doubt once and for all. Nothing is more unpleasant to a sensitive primigravida than vaginal examination constantly repeated. If you anticipate that she is not going to be very tolerant, there can be no objection to putting her lightly under anæsthesia for it. Towards the end of labour watch carefully for the passage of meconium and listen frequently to the fœtal heart. You know, of course, that the fœtus is practically never in danger as long as the membranes are intact, and that the mother is practically never in danger as long as the fœtus is alive. Remember that every now and again you may avoid an instrumental delivery by making the patient turn from her side on to her back.

And now about forceps. Midwives get a much greater percentage of spontaneous deliveries than do doctors, and the factors determining the difference seem to me to be three. First, most of the abnormal cases come eventually under a doctor's care. Second is the patient's capacity for bearing pain: inasmuch as the sensitive type usually employ a doctor rather than a midwife, the doctor's forceps delivery percentage will tend to be high. The third factor is the attendant's capacity for exercising patience, and in that midwives are notoriously ahead of doctors. I do not believe that a forceps delivery at the proper time and in competent hands adds appreciably to the maternal risks, and it is probably safer than the indiscriminate exhibition of pituitrin, but the man who always puts on forceps as soon as he can is bound to run up against trouble before very long. There are three forceps operations—low forceps, high forceps, and damned high forceps. This last is occasionally performed by an intern during his first fortnight of office. After the blades have slipped once or twice, the case will very likely become complicated by a prolapse of the cord, and he will soon have explored the whole range of operative obstetrics. Much of the blame must be laid at the door of that provocative phrase, "the cervix is fully dilated." To say that forceps should not be used until the cervix is fully dilated is to imply that they may be used *the moment* the cervix reaches full dilatation. Hence frequent vaginal examinations to find out the state of the cervix, followed by manual dilatation, so called, "to put her out of her misery, doctor," and a "difficult forceps delivery." You must never allow yourself to be rattled into premature attempts to "get it over." What happens when the cervix does become fully dilated? "The drawing up of the cervix removes the uterine tissues and a considerable amount of parametric tissue from between the head and the brim, thus increasing the available space. The head enters the brim, and with the next few pains the greatest diameter passes and the head slips easily into the cavity of the pelvis to reach the constriction of the outlet" (Gibbon Fitzgibbon, *Contracted Pelvis*, 1924). Swear a great oath never to put on forceps *until the head is on the perinæum*. If you can keep to this, there will be less sepsis, fewer tears of

perinæum or cervix, only the minimum amount of intracranial injury, and you will sleep better. I am well aware there may be exceptions to this rule, but one exception every two or three years will be quite enough to prove it in any ordinary practice. When the head is on the perinæum, and when it ceases to advance in spite of good pains, it should be "lifted over" with forceps. I may add that the administration of chloroform, much as the patient appreciates it, is probably responsible for a good deal of delay on the perinæum.

In order that you may the more vividly realize with what great care and gentleness a forceps delivery should be undertaken, I suggest the following prescription: Go up to Elizabeth, and having selected a newborn infant, put him under a blanket, or better still in the dummy, apply the blades in the proper manner, and draw him forth. You will then understand that brute force is absolutely unpardonable in midwifery. As to the actual technique of forceps delivery, I would remind you of a few small points. Let your methods be antiseptic rather than aseptic. Try and remember to pass the catheter; it is so easily forgotten. It is worth while in a primigravida to dilate the vagina using the method described by Potter, with whose technique of breech delivery you should, incidentally, be thoroughly familiar. Clover's crutch is an abomination, and should never be used if it can be avoided; by extreme forced flexion of the thighs on the trunk the perinæum is made taut, so that further stretching can hardly fail to produce a moderate tear. If you have enough assistants, let the legs be held and lowered as the head advances, so that the angle formed by thigh on trunk be 135° or even more. If you have only one assistant, use the lateral position. If you restrict your forceps operations to the low variety, it does not matter what type of instrument you use. Avoid, therefore, those patterns which present a multitude of rods, screws and joints, and ask to see Wagstaffe's before you decide. But whatever you do don't buy one of those prehistoric obstetric outfits—sharp hook, blunt hook, cephalotribe and cranioclast, de Ribes' bag introducer, and what not. If things are really as bad as that, get the woman into hospital, or get an expert to help you.

One word about the question of sepsis. Clinically there seem to be two types. One fulminates, killing the patient within a few days, and this variety seems as likely to follow a spontaneous as an instrumental delivery. The severity of the other varies directly with the amount of intra-uterine manipulation. Study the puerperal temperature charts of normal cases. In almost all there is just a little fever. Have you ever looked into the mouth of a child three or four days after tonsillectomy has been performed? Why should the healing process be any different in the uterus? It has been shown pathologically that the uterus becomes infected after every labour, and I have no doubt that the placental site closely resembles in appearance the tonsillar fossæ. Under these conditions, what possible use can there be in attempting a definition of puerperal sepsis? It is said that all handsome men are slightly sunburnt. It is certain that all puerperal women are slightly septic.

G. F. ABERCROMBIE.

THE PRESENT POSITION OF PSYCHO-THERAPY.

PSYCHO-THERAPY, by which is meant the direct treatment of ill-health by psychological methods, does not appear to have had any modern scientific thought directed towards it until James Braid practised his hypnotic suggestion in Manchester and wrote an important book on the subject, which he called *Neurypnology*. This book was published in London in 1852.

Braid died in 1860, the year in which Dr. Liebeault opened his dispensary for the treatment of mental disorders by the same methods at Nancy. Since the time of Liebeault the treatment of disease by suggestion has always been associated with the Nancy School, while there have always been some practitioners of the art in England.

Although these methods produced cure in certain cases and others were considerably benefited by them, psycho-therapy was not considered to be a recognized part of medical practice by the medical profession as a whole.

Meanwhile Freud, in Vienna, had begun to treat patients by his analytical methods, and was building, upon the results he obtained, his theories of the causation of mental disease and the technique of psycho-analysis; while more recently, Jung, at Zurich, who had been a pupil at Freud's clinic, has elaborated his analytical methods by word-association as distinct from Freud's free-association method.

These three methods for the treatment of psychological disorders were in use in England in the early years of this century, and although each had its following amongst medical men, in this country, the medical profession was not yet prepared to acknowledge that psycho-therapy held a definite place in medical science.

The change of attitude, which has resulted in the universal acceptance of the part played by psycho-therapeutics in the treatment of disease, is one of the

direct results of the experiences gained in the Great War. The enormous number of mental disturbances which occurred in the Army, causing a disablement just as complete as resulted from serious wounds, and even preventing the effective return to civilian life of those who were discharged from military service, presented a problem so acute as to attract the attention of both civil and military authorities.

As evidence of the small amount of knowledge of mental disorders possessed by the Army medical authorities at the beginning of the war, it was a fact that at first these cases of psycho-neurosis were looked upon as something new in medicine, and it took some time before it was recognized that the psycho-neurosis of war did not differ from that of peace-time conditions, either in its cause or its symptoms, only that for the first time large numbers of men were disabled by these means without any evidence of physical disturbance.

It is interesting now to recall the efforts that were made to find some physical explanation for these disorders, and the name "shell-shock," which was first of all given to these cases, is a memento of one such attempt at explanation, the idea being that the concussion caused by the explosion of the shells produced some pathological change in that part of the central nervous system which corresponded with the symptom that was produced. This theory was at once disproved by the appearance of precisely similar symptoms in men who had never been under shell-fire.

In a similar way all these physical theories were discounted, and finally it came to be recognized that all these cases were the result of psychological disturbances, and differed in no particular from those which had previously been recognized and treated by psycho-therapeutists before the war, except that the war cases occurred in large numbers, and were comparatively easy to treat because they were recent and acute, and because the cause of the condition was too obvious to remain unrecognized.

It thus came about that psycho-therapeutics received the official recognition of the medical profession as a whole, and, thanks to this attitude, the art has made rapid progress, so that cases are now being treated successfully, not only by those who have made a special study of the subject, but by many of the more advanced consulting physicians and by not a few general practitioners.

This state of affairs is sure to become more definitely established in the future, and it is certain that no medical man will be considered fully equipped until he is able to recognize those cases which are suitable for psycho-therapeutic treatment, and to use the correct methods for their cure. That the usefulness of psychological methods of treatment has now come to be recognized is shown by the fact that the Universities and other examining bodies now offer a diploma of psychological medicine, and that in nearly every hospital of importance a department of psychological medicine has been established similar to that which was organized by Sir Robert Armstrong-Jones at St. Bartholomew's Hospital.

The methods that are available for the treatment of psychological disturbances can be divided into: (1) Simple suggestion treatments, with or without hypnosis; (2) some form of analytical treatment; and (3) treatment by explanatory conversations and re-education or synthesis.

Treatment by suggestion can be dealt with quite briefly. Its object is the removal of symptoms. The patient is either hypnotized or relaxed, and the suggestions for the removal of the symptom are given to him. In hypnosis or the relaxed state his critical sense is in abeyance, so that the suggestion is accepted and the patient behaves in accordance with the suggestion and as if the symptom had never existed.

The element of suggestion enters very largely into every kind of medical practice. The suggestion conveyed by the attitude of the physician towards the patient and by the medicine or other method of treatment that he prescribes has long been made use of, and consciously recognized by most successful medical men. It has been found that suggestion alone rarely produces permanent cure, for the reason that it fails to affect the underlying psychological disturbance which gives rise tot the symptom.

The analytical methods are deserving of more attention, and in a brief survey, such as this, it is the method of analysis introduced by Freud which will be considered. It is not too much to say that the discoveries of Freud have revolutionized psychological medicine. It was Freud who first called attention to the fact that the symptoms, or the group of symptoms, which had long been known by the names of "neurasthenia" and "hysteria," resulted from the repression into some part of the mind outside consciousness of wishes which are in conflict with the social ideal of the individual, and cannot, therefore, be acknowledged or admitted to consciousness.

For the better understanding of his theory he divided the mind into three levels: (1) That part of the mind containing elements which could never be brought into consciousness by the unaided efforts of the individual he called the "unconscious." (2) Another part of the mind in which were elements which could be brought into consciousness by the individual himself, but only with difficulty, he called the "fore-conscious." (3) While the "conscious" level consisted of experiences

occurring in everyday life and memories which could be brought readily into consciousness without offence to the social ideals. The above is a very bald and incomplete description of Freud's division of the mind, but will serve for the simple explanation of his method, which it is proposed to give here.

It has been mentioned that Freud's theory resulted from his experiences in the analysis of patients who were suffering from some form of psycho-neurosis. This analysis is quite simple to carry out and can be briefly described.

The patient sits in a comfortable armchair or reclines on a couch in a comfortable position, while the analyst sits near by and out of view of the patient. The patient is instructed to close his eyes and to describe everything that comes into his mind. The process is called "free-association," because the mind is allowed to wander on from subject to subject, each in turn suggested by association with that which went before. The patient is told to disclose everything that enters his mind, no matter how distasteful it may be, and no matter how much he would prefer to avoid any mention of it. Long pauses, uneasy movements and emotional states occurring during this free-association are indications that some unconscious complex is approaching consciousness, and the practitioner makes a note of this. He should make no suggestions to the patient and should give no explanation of the phenomena, simply encouraging the patient to go on with his association when these pauses occur. By this means the whole of the contents of the patient's mind are gradually disclosed, the object of the analysis being to induce the patient to disclose them to himself as well as to the practitioner, and thereby to gain a complete understanding of the contents of his own unconscious mind.

It is the practice amongst most analysts to see their patients daily from half an hour to an hour, and to continue the analysis until the symptoms disappear. Such treatments occupy months and sometimes years to complete, and the disadvantages of such a slow method, which are sufficiently obvious, will be referred to when the value of the different methods comes to be considered.

The analysis of dreams is an essential part of psycho-analytical methods. It was Freud's view that the repressed psychological elements or complexes are expressed in dreams, appearing in the dream consciousness disguised and changed into some symbolical form, and the patients are instructed to record their dreams at the moment of waking and as soon as they occur. These dreams are then interpreted in accordance with a symbolical code, which is fully described in Freud's books. His experience with this method of analysis led him to believe that the basis of all mental disturbance was the repression of some sexual wish. He found that in every case of analysis, when he had reached a certain point in the process, some profound sexual repression came to consciousness, the sex wish which was being repressed being frequently, perhaps most commonly, a sexual wish that was abnormal, a wish for the expression of sex in some abnormal manner. So frequently do these repressions obtain release in Freudian analysis that a tendency has arisen for the psycho-analyst to look upon sexual repressions as the cause of every psycho-neurosis.

Such a brief account does not do justice to Freud's method, and those who are interested in the subject are advised to read Freud's own book before passing judgment upon the method as a whole, for it is undoubtedly true that a great many cases of psycho-neurosis, sometimes the more obscure forms of psycho-neurosis, have been cured by psycho-analytical methods.

However we respond to Freud's teaching, the one part of his theory which is now largely accepted and utilized by the psychologist is his theory of repression to an unconscious level of wishes which we cannot express and at the same time retain our place in our own social circle.

In the foregoing account of the psycho-analytical methods it was mentioned that the Freudian method of analysis should be carried out by the patient without assistance from or explanation by the practitioner. In actual practice it is probable that every psycho-analyst explains to the patient whatever is disclosed of the contents of the mind during analysis, although this is contrary to the psycho-analytical technique.

(To be continued.)

ERNEST SNOWDEN.

TOPE FISHING.

I THINK one might have added, after Kipling, "and all that that implies," for the preliminary and accessory incidents had an interest of their own.

I first heard about tope through Capt. Yeats's article in the *Daily Mail* a few weeks ago, and through his good offices was able to get in touch with Mr. Johnnie Bull, who is the recognized authority on this sport. His name acts like magic with the local fishermen, and so one was able to avoid the gropings and waste of time which usually occupy the first few days of a holiday in a new place. I arrived at Hastings at 8 p.m., and

the same evening was able to get news of "Kesher" Wimburn, the best known among these boatmen who are willing to go after tope. He was just recovering from having had his hand stung by a "wyvor," as they called it. A weaver is an athletic little fish, very good to eat, but bad to handle. I remember an article in the *Lancet* or *British Medical Journal* on the weaver and its poison a year or two ago. There are several types apparently, but they all have a gland at the base of one of the dorsal fin spines, which automatically discharges its poison into the wound made by the spine. It must have a selective action on nerves; the pain is agonizing, and Kesher's finger was still anæsthetic a week after the sting.

I had to be in the fish market by six the next morning to make sure of meeting him, and I spent an hour watching the sale of the fish just brought in. I was surprised to see halibut and salmon, and other North Sea fish; the Grimsby trawlers avoid the risk of a glut at their own place and get a better price by bringing their catch to the Channel ports. Apparently this pays, in spite of the petrol used in getting there; the boats all seem to have engines these days.

The buyers have to know their own mind in the type of auction. The salesman starts at a price per stone well above what anyone is likely to bid, and goes down by threepenny steps to begin with—"Four and six, four an' a bunce, four shillings." The first man to nod gets the fish, and within five seconds the next lot is being cried. I wonder how the method would work at Christie's! The salesman's commission is 9*d*. in the £, at which he makes five hundred a year, I was told. Mackerel was what I was interested in, as bait. They were going at three shillings per stone, and I bought one and a half stone—big ones are best.

Among the lots laid out on the floor was one that gave me a little thrill: four large tope, looking like stranded submarines. A tope is a fish of the shark persuasion, much bigger than a dog-fish, and more obviously built for speed. They run to about 4 ft. in length, and are of a uniform slate colour above and white below. The mouth is well underneath the head, and the under-surface is flattened in the fore-part of the fish. This presumably helps it in going along the bottom after flat-fish; and, as has been found in racing cars, this form of stream-lining prevents the trapping of air (or rather water) between the fore-part and the ground, with a consequent increase of resistance. The face of skate is probably a little uglier than that of a tope, but for sheer balefulness a tope takes a lot of beating.

By 9.30 I had purchased all my tackle, except piano-wire, at Massingham's tiny shop, and was helping to launch the boat. It was 21 ft. in length and yawl-rigged, built during the war, with a 6 h.p. two-cylinder engine. The crew consisted of Kesher and his mate, on whom he rained *sotto voce* curses at the least imperfection in technique either of managing the craft or of making the cargo happy. The sea was a bit choppy, and I was surprised at not feeling ill during the half hour's run to the "hard" where we were to fish. The sea floor of the hard consists chiefly of "bombs" or large round stones, and on them live numerous whelks; also sea-anemones, which are thought highly of by mackerel, it appears. Tope appear off our shores when the mackerel first show up, about June. And they stay till January. I could hardly believe my ears when I heard this, for I have hitherto never been in a place at the right time. "You should have been 'ere about a fortnight ago, Sir; we was balin' of 'em out 'ere then" is the sort of thing I am accustomed to hear. Also the best tope fishing is to be had only on the calmest days—very heartening news.

We prepared our tackle and bait during the journey. The rod is only 6 ft. long and very stiff, with big porcelain-lined rings. The line is the thickest I have seen, and is wound on to a 5-in. reel. The rapid winding-in of a smaller reel would soon tire one's wrist. The hook is a No. 9—very big indeed—and it has to be connected to the line by a piano-wire trace, as catgut gets bitten through at once. A 5-oz. sinker is attached to a "boom." This is a gadget fixed on the line about 20 yards from the hook, but can be released so as to permit the lead to move freely on the line during the reeling-in of a fish. The bait consists of a whole mackerel, through whose flanks the hook or hooks present, the tail being distal.

We anchored on the hard about 11 o'clock, and in about a quarter of an hour the reel began suddenly to run out. One must resist the very natural temptation to strike immediately, because the mackerel is seized transversely to begin with, and you have to let about 100 yards of line run out first, so as to give him time to turn the bait end-on and swallow it well down. Why the tope carries it about in his mouth in this way is not clear. Perhaps it is equivalent to rolling a rare wine about on the palate; he likes to savour the mackerel first, so that there is a good psychical flow of gastric juice ready to greet the bolus on its arrival in the mid-gut. Well, at last the moment comes when it is permitted to strike. Rather doubting whether he is still on, you strike good and hearty; from that moment onwards you are in no doubt whatever whether he is on or not. He pulls with about the same vigour as you would expect from a mastiff on shore, and there are moments when you have all you can do to stay with him, especially if any extraneous circumstance has

weakened your resistance. This had happened in my case; I experienced about this time a certain disharmony of labyrinthine impressions, so that no sooner had Kesher skilfully gaffed the infuriated fish into the well of the boat than I turned my back on the three of them for a season.

Considerably refreshed I climbed back into the ring, and proceeded with the matter of rebuking the fish, the lashing of whose tail by this time passed all decent restraint.

I had looked forward to this particular moment because I had brought down for the purpose a life-preserver which I had purchased when I was a special constable, but had not previously had a chance of using! Forgetting the lessons of biological dissecting days, I aimed at where any ordinary animal might be expected to keep its brain, without much result, except that it blinked and winced rather like a dog whom you have cuffed over the head. The heel of Achilles in the tope is much further forward it appears. And not until I had finally smitten him crisply just abaft the tip of his nose did he take any notice. On receipt of this blow he stiffened, and I'll swear looked reproachfully at me ere he ceased all movement except for an occasional spasm of the gill-cleft. You leave the removal of the hook to the boatman while you fix another trace and hook already prepared. Occasionally, I am told, the tope breaks water and leaps into the air a hundred and twenty yards from the boat, like a tarpon, but I did not see this happen in the case of either of the two I caught that day.

We weighed them and found that one was just over two stone and the other just under. Both were males, and consequently put up a much better fight than could be expected of the females, which are still gravid about this time. Tope flesh is sold in London, I believe, disguised under various names, such as "rock salmon," at 6*d*. a pound and more; but you can buy a whole one for sixpence in the fish-market.

I could have caught more, I imagine, but I was beginning to feel an intense dislike for the accessory incidents such as marred the playing of my first fish. I was very glad to get back to shore, but the game was well worth the candle. More and more folk are getting to hear about the sport, and probably it will soon be overcrowded, like everything else. But at present it is one of the best ways of spending a week-end that I have found.

BEDFORD RUSSELL.

DAVID LIVINGSTONE.

A FEW months ago a film appeared depicting the life of Dr. David Livingstone. Shortly afterwards the chance discovery that he had lived and worked very close to the Hospital, added to my impressions of the film, led me to read his life, from which I have gathered together some facts of interest to me and which may interest others.

During the year 1839 Livingstone was engaged in getting into touch with workers in the missionary field, and while doing so lived in Aldersgate Street. At about the same time he met Dr. Bennett, afterwards Sir J. Risdon Bennett, who became President of the Royal College of Physicians. In his contribution to Livingstone's life he wrote: ". . . He had little or no acquaintance with the practical departments of medicine, and had had no opportunities of studying the nature and aspects of disease. . . . I was at that time Physician to the Aldersgate Street Dispensary, and was lecturing at Charing Cross Hospital on the practice of medicine, and thus was able to obtain for him free admission to the Hospital practice as well as attendance on my lectures and my practice at the Dispensary. I think I also obtained for him admission to the ophthalmic hospital in Moorfields."

The Dispensary referred to still exists as the Royal General Dispensary, which moved to its present site in Bartholomew Close in 1879.

Livingstone returned to Scotland, and took the diploma of Licentiate of the Faculties of Physicians and Surgeons of Glasgow in November, 1840. He was nearly ploughed for adhering firmly to his views in regard to the stethoscope, which apparently were not well received by the examiners.

The next year, 1841, he wrote to Dr. Bennett, from Kuruman in the Transvaal, giving some idea of his medical work in Africa. ". . . I have an immense practice. I have patients now under treatment who have walked 130 miles for my advice. . . . They are absolutely omnivorous. Indigestion, rheumatism, ophthalmia are the prevalent diseases. They are excellent patients . . . there is no wincing; everything prescribed is done instanter. Their only failing is that they become tired of a long course. . . . In cutting out a tumour an inch in diameter they sit and talk as if they felt nothing." Livingstone does not appear to have written much about the medical side of his life.

In 1844, the year before his marriage, he was attacked by a lion, and of his narrow escape from death everyone knows. His left shoulder was mauled and the humerus

broken at the junction of its upper and middle thirds. To quote again: "For thirty years afterwards all his labours and adventures, entailing such exertion and fatigue, were undertaken with a limb so maimed that it was painful for him to raise a fowling-piece, or in fact to place the left arm in any position above the level of the shoulder." He thought little of it himself, and wrote home to his father, "Do not mention this to anyone. I do not like to be talked about." Later on, in 1864, he would not allow Prof. Syme to operate upon him because he was afraid that it would get into the newspapers.

In the Hospital Museum is a specimen of which the description reads:

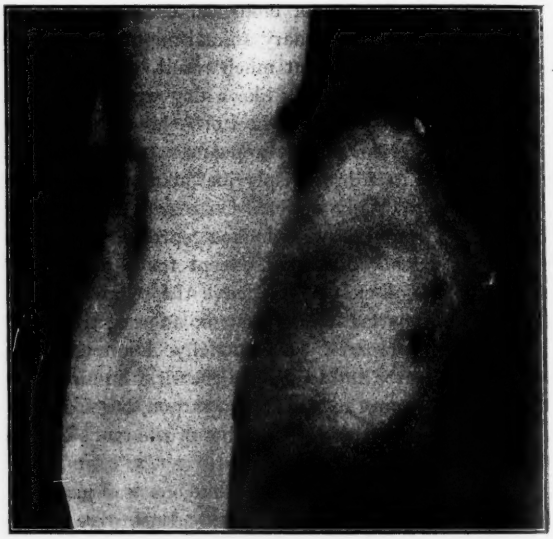
> 863. Cast of the left humerus of Dr. Livingstone, showing a false joint a little above the middle of the bone. The fracture was caused by the bite of a lion thirty years before his death. The left humerus was one inch shorter than the right. The lower portion of the shaft is slightly rotated outwards. A small piece of detached bone was found lying in a cyst in front of the fracture.—See *Lancet*, i, 1874, pp. 565 and 888.

Another such cast is to be seen at the Museum of the Royal College of Surgeons.

Livingstone died, according to the stone in Westminster Abbey, where his body lies, on May 4th, 1873, at Chitambo's village, Ilala. After his death the natives with him removed and buried his heart and other viscera, and dried the remainder of his body in the sun for fourteen days. It was then wrapped in calico, bark and sailcloth and carried to the coast, where it arrived the following February. On arrival in England in April the remains were taken to the Royal Geographical Society, and a post-mortem examination was made by Sir William Fergusson and other medical men. Sir William Fergusson, writing in the *Lancet* (April 18th, 1874), said: "Exactly in the region of the attachment of the deltoid to the humerus there were indications of an oblique fracture. A closer identification and dissection displayed the false joint that had so long ago been so well recognized by those who had examined the arm in former days. . . . The first glance set my mind at rest, and that, with the further examination, made me as positive as to the identification of these remains as that there has been among us in modern times one of the greatest men of the human race—David Livingstone." T. H. G. S.

NOTES ON A CASE OF GIANT PRE-PATELLAR BURSA.

THE interesting feature of this case was the SIZE of the bursa, which meaured 11½ ins. from above downwards and 9¾ in. from side to side. It weighed 63 oz. The patient, a woman of 56, first noticed that she had a "housemaid's knee" on the right side some 30 years ago. She stated that the "tumour" gradually became larger, but as it caused her no pain or inconvenience she saw no reason why she should apply for medical advice or treatment. A week



PHOTOGRAPH OF MR. RODNEY MAINGOT'S CASE OF GIANT PRE-PATELLAR BURSA.

before attending hospital, however, she inadvertently scratched the surface of the bursa, which became locally inflamed and painful. She requested that the inflammation should be treated, and that the bursa should be left alone. She eventually consented to have the bursa removed. A skiagram was taken of the knee and bursa, and this showed that the knee joint and patella were normal, and that the bursa was trabeculated (lobulated). In the skiagram a patchy calcification of the walls of the bursa could be clearly seen. The removal of the bursa presented no difficulties, although its posterior surface was firmly adherent to the aponeurosis of the quadriceps extensor muscle and the patella. The specimen was kindly mounted and preserved intact for me by Dr. Robert Donaldson, and was presented to the Royal Waterloo Hospital. RODNEY MAINGOT.

TIMES OF ATTENDANCES IN THE OUT-PATIENTS' AND SPECIAL DEPARTMENTS.

	Monday.	Tuesday.	Wednesday.	Thursday.	Friday.	Saturday.
Medical Out-patients	Dr. G. Graham 9 a.m.	Prof. Fraser and Dr. Geoffrey Evans 9 a.m.	Dr. Hinds-Howell 9 a.m.	Dr. A. E. Gow 9 a.m.	Prof. Fraser and Dr. Geoffrey Evans 9 a.m.	Dr. Hugh Thursfield 9 a.m.
Surgical Out-patients	Prof. Gask and Mr. Dunhill 9 a.m.	Mr. R. M. Vick 9 a.m.	Mr. Harold Wilson 9 a.m.	Prof. Gask and Mr. Dunhill 9 a.m.	Mr. J. E. H. Roberts 9 a.m.	Mr. W. Girling Ball 9 a.m.
Diseases of Women	Dr. Shaw 9 a.m.	—	Dr. Donaldson 1.30 p.m.	—	—	Dr. Shaw 9 a.m.
Ante-Natal Clinic .	—	—	—	Dr. Donaldson 12.15 p.m.	—	—
Orthopædic Department	Mr. R. C. Elmslie 1 p.m.	—	—	Mr. R. C. Elmslie 1 p.m.	—	—
Throat and Nose Department	Mr. Harmer 1 p.m.	Mr. Rose 9 a.m.	—	Mr. Harmer 9 a.m.	Mr. Rose 1 p.m.	—
Aural Department.	Mr. S. R. Scott 1 p.m.	Mr. T. H. Just 9 a.m.	—	Mr. S. R. Scott 9 a.m.	Mr. T. H. Just 1 p.m.	—
Ophthalmic Department	Mr. Foster Moore 1 p.m.	Mr. Rupert Scott 1 p.m.	—	Mr. Foster Moore 1 p.m.	Mr. Rupert Scott 1 p.m.	—
Skin Department .	—	Dr. Adamson 9 a.m.	Dr. Adamson 9 a.m.	—	Dr. Adamson 9 a.m.	—
Psychological Department	—	—	—	—	Dr. Porter Phillips 1.30 p.m.	—
Electrical Department	Dr. Cumberbatch Males at 1 p.m.	Dr. Cumberbatch Females at 1 p.m.	—	Dr. Cumberbatch Males at 1 p.m.	Dr. Cumberbatch Females at 1 p.m.	—
X-ray Department	9.30 a.m. and 1.30 p.m.	9.30 a.m. and 1.30 p.m.	9.30 a.m.	9.30 a.m. and 1.30 p.m.	9.30 a.m. and 1.30 p.m.	9.30 a.m.
Exercises and Massage Department	9 a.m. and 1.30 p.m.	9 a.m. and 1.30 p.m.	9 a.m. till 1 p.m.	9 a.m. and 1.30 p.m.	9 a.m. and 1.30 p.m.	9 a.m.till 1 p.m.
Diseases of Children	Dr. Thursfield 1 p.m.	—	Dr. Thursfield 1 p.m.	—	—	—
Dental Department	Mr. Fairbank 9 a.m.	Mr. Fairbank 9 a.m. Mr. Coleman 10 a.m.	Mr. Woodruff 9 a.m.	Mr. Fairbank 9 a.m.	Mr. Woodruff 9 a.m. Dr. Austen 10 a.m.	Mr. Woodruff 9 a.m.
Tuberculosis Dispensary	6 p.m.	12.30 p.m.	11.30 a.m.	6 p.m.	12.30 p.m.	—
Venereal Department (Golden Lane, E.C.)	Females and children 12 to 2 p.m.	—	Males 12 to 2 p.m.	Females and children 12 to 2 p.m.	Males 5 p.m. to 7 p.m.	—

WITH WORDSWORTH IN THE "BOX."

HOW red that forehead's hot expanse!
How blear that heaven-directed glance!
"I got sich a naggy naggy pain!
They starts be'ind up 'ere,
They stops and then comes back agen
An' then they disappear!"
So spake Smythe (Ada) when she drew
Her corsets from their station:
So spake: not ceasing to pursue
Her tuneful protestation.

"Me 'and an' fice alike is swelled;
Last Sunday night I sat an' yelled.
'''Ow queer,' they said, 'she's got ter be.'
They says the change 'as come ter me.
Oh Doctor, shall I see agen?
Oh Doctor, *there's* that windy pain!
Its fetched me gastric stomach back
That took me once at Wapping:
I 'eaved and retched the 'ole attack
An' 'iccupped wivout stopping.

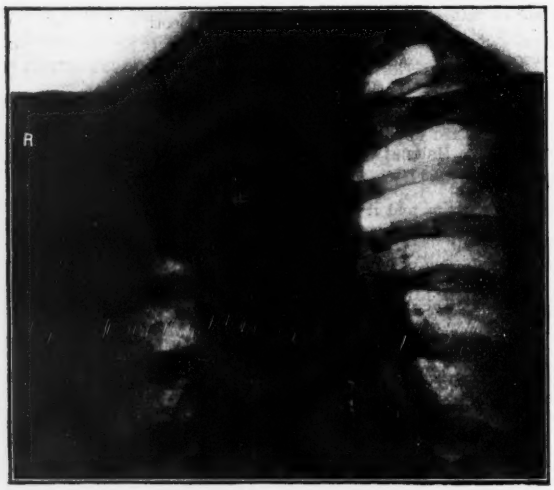
"I got young 'Erbert up an' Nell;
Took queer they was wiv Mrs. Bell.
'E ate a whelk which wasn't dead
An' caught a colicky croup in the 'ead.
She comed out in a prickly 'eat;
Its spots they are, all in 'er feet.
I pricked 'em wiv a winkle pin
(We'd 'ad a lot for dinner),
But then young 'Erb 'e sicked agen,
So I left the old pin in 'er."

* * * *

"Yes, put them and yourself to bed.
Next, please," the wily doctor said.

A CASE OF CHRONIC APICAL PNEUMONIA.

MALE, æt. 38, developed lobar pneumonia in December, 1924. The disease followed the ordinary clinical course, and ended by crisis in the usual time. Since then, however, the patient has been much troubled by cough, and has always had a good deal of greenish, purulent expectoration. The general condition recovered, and is now normal and excellent, the temperature (rectal) is not raised, he has been gaining weight, but the cough and expectoration persist. I saw him for the first time a few weeks ago,



when he came to Davos, hoping that the mountain climate will be of benefit to him.

On examination it is seen that the whole of the right side of the chest, especially the upper part, is greatly contracted and pulled in, the shoulder being flattened and dropped and the expansion poor. The note over the upper lobe is very dull, the breath-sounds are bronchial in type, and there are numerous moist *râles*; the vocal resonance and vibrations are increased. In fact, on first sight one would say without hesitation that the case was a clear one of pulmonary tuberculosis undergoing a considerable amount of fibrotic change in the upper lobe. The radiograph (see Fig.) shows an intense, opaque shadow in the upper lobe of the right lung, sharply defined from the rest of the lung; it also shows very clearly the great contraction of this side of the chest. The sputum, which has been examined on many occasions, has always been negative as regards the presence of tubercle bacilli. Pneumococci, however, are present in considerable numbers, and some other secondary organisms.

During the whole course of the case, the patient's general condition, absence of fever, even after exercise, the absence of tubercle bacilli in the sputum, in spite of the fact of the sputum being abundant and very purulent, point to the conclusion that the condition is not one of tuberculosis, but is one of chronic apical, non-tuberculous pneumonia, which is, I think I am right in saying, a somewhat rare condition.

I am indebted to Mr. P. G. Sutton, M.S.R., of the X-Ray Institute, Davos-Platz, for the radiograph.

BERNARD HUDSON.

TWO CASES OF ECLAMPSIA.

THE following two cases of eclampsia seem to have sufficient interest to warrant recording, and we are indebted to Dr. Donaldson for permission to publish them.

(a) *A Case of Ante-Partum Eclampsia.*

Mrs. A. W—, æt. 27, was brought up to hospital, having had two fits earlier in the day.

Her history showed that she had been married for nine years, but was now pregnant for the first time.

The period of gestation was thirty weeks.

The early months of pregnancy had been normal, but for the last two months she had been suffering from increasing swelling of the feet and legs, and from blurred vision and "spots in front of the eyes."

For one month she had been troubled with intermittent frontal headaches and vertigo, with occasional epigastric discomfort. She had felt lethargic and depressed.

On the day of admission she had had two fits before coming to hospital, with an interval of a few hours between them. Very soon after her arrival she had another fit, typically eclamptic in nature, consisting of a preliminary stage of spasmodic respiration with some twitching, followed by a stage of violent tonic contraction of all her muscles, finally leaving her in a semi-comatose condition. The fit lasted about two minutes, but the patient was not fully conscious for eighteen hours, and at no time remembered the events of the day of admission.

On examination the patient was a strong, healthy-looking woman. Pulse 84; temperature 99·6° F.; blood-pressure 185/110, during fit 210/—. She was very cyanosed during the fit.

There was marked œdema of her feet, legs, arms and in the sacral region; her face was puffy, but her vulva

normal. The abdomen was distended by the pregnant uterus, which was enlarged to correspond to thirty weeks' gestation.

The fœtal heart-rate was 120—lie and presentation vertex R.O.A.

The urine became solid on boiling and contained 1·4 per cent. albumen.

Blood-urea 37 mgrm. per cent. Urinary diastase 25 units.

The patient was put to bed in a darkened room and kept as quiet as possible.

A modification of Stroganoff's drug and diet treatment was carried out as shown:

Day of fits: hour after fit.	Drug.	Fluids.
0	Morphia gr. $\frac{1}{6}$	—
$\frac{1}{4}$	Calomel gr. v	—
1	Chloral hydrate gr. xx *p.r.*	—
$1\frac{1}{2}$	—	Water ℥x; vomited ℥vj.
2	—	Water ℥x; vomited ℥iv.
3	Morphia gr. $\frac{1}{4}$	—
5	Calomel gr. v	—
7	Chloral hydrate gr. xx *p.r.*	Saline Oj *p.r.*
13	Chloral hydrate gr. xx *p.r.*	Saline Oj *p.r.*
17	—	Water ℥iv
21	Chloral hydrate gr. xx *p.r.*	—
23	—	Water ℥x
24	Calomel gr. v	—

The condition of the patient had by this time greatly improved. She was kept in the darkened room, but she was allowed increasing amounts of water, and two days later unlimited milk and water.

For six days she had mag. sulph ℥ij every evening.

Except for a slight rise in blood-pressure, she steadily improved from the hour of admission.

The œdema grew rapidly less and was not apparent four days after admission, when her mental condition was quite normal. Slight albuminuria persisted. The fœtal heart was not heard after the last fit.

Clinical Course.

Day after fits.	B.P.	P.	T.	Urine.	Albumen.	B.O.	Mental state.
1st	166/120	88	97·8°	℥xxj	0·8%	1	Weak.
2nd	185/140	68	99·0°	℥liij	0·2%	1	Depressed.
3rd	170/120	80	97·6°	℥cxij	·01%	1	Brighter.
4th	205/130	68	98·8°	℥xcij +	0·08%	3	Normal.
5th	175/120	80	97·8°	Normal quantity	0·18%	1	,,
6th	165/125	80	98·6°	Do.	0·11%	3	,,
7th	155/105	80	97·8°	,,	0·08%	2	,,
8th	145/105	88	98·0°	,,	0·05%	2	,,

During the evening of the sixth day after admission the patient had a few very slight labour pains, which resulted in rupture of the membranes. She was then free from pain until the following evening, when, after a few very moderate bearing-down pains, which lasted for only half an hour, she bave birth to a macerated fœtus; there was no hæmorrhage. The placenta was expressed by Crédé's method forty-five minutes later. It was normal and the membranes were intact. The labour and delivery had no ill-effects on the patient. After the fifth day from admission she was allowed thin bread and butter, and two days later a light diet of fish, bread and butter, etc. She continued to make good progress, and was discharged twenty-six days after admission.

One month later she was seen in the women's out-patients'. She was then complaining of some orthopnœa and vertigo. She had traces of albumen in her urine, and her blood- pressure was 150/106.

She was seen twice more at intervals of a month and was found to be in normal health. E. S. V.

(b) *A Case of Post-Partum Eclampsia.*

Mrs. W. H—, æt. 37, a multigravida, was admitted to Charity Ward with œdema of the ankles and feet and albuminuria. The patient was thirty-nine weeks pregnant.

Evening nausea had been marked throughout the pregnancy. Œdema confined to the ankles and feet was noticed at the thirty-second week. The patient also complained of spots and coloured lights before the eyes, and well-marked occipital headache during the last two weeks of pregnancy. Albumen was discovered in the urine at the same time and the patient found to have a mitral lesion and a blood-pressure of 200/100 mm. Hg. On examination of the urine it was found to contain 50 units of diastase, albumen, globulin and urobilin.

On examination of the patient there was a mitral systolic murmur and the abdomen was rather protuberant, with a girth of 41 in. The fœtal parts could not be clearly palpated, nor could the fœtal heart-sounds be heard. There was also slight œdema of the feet and ankles.

The patient went into labour on March 11th at 8.30 a.m. and by 11.30 a.m. she had been delivered of triplets. The first presented by the breech, the second by the vertex, the third being born, together with the placentæ, in a macerated condition. The first two survived and were healthy on discharge. After the birth of the third child the patient was in a semi-comatose condition, was passing large quantities of albumen in her urine and had a systolic blood-pressure of over 200 mm. Hg.

The patient had her first fit on March 11th at 6.20 p.m., seven hours after the birth of the last child, a second at 7.0 p.m., and a third at 7.30 p.m. At the commencement of the fit the patient hyperextended her head and

back, but did not go into complete opisthotonos, her legs being flexed on the body and at the knees. During this stage she was very cyanosed and remained so for one minute. A spatula was inserted into the mouth at this stage. A clonic stage then commenced and lasted for another minute. After this stage the patient sank into coma again. During the fit the pulse-rate was raised from 80 to 120 per minute, and the conjunctival reflex was diminished but not entirely absent. Between the fits the patient had periods of quietness alternating with periods of restlessness. Her breathing was stertorous throughout, and at intervals of five minutes the patient experienced a spasm of the left side of the face, the angle of the mouth being drawn up and the eye tightly closed. These lasted for fifteen seconds. During that night and the following morning the patient was in a comatose condition, and during the remainder of the following day her mental condition was bad. She roused when spoken to, but could not understand what was being said to her. The patient never had incontinence of urine, nor of fæces, but a catheter had to be passed for two days.

The patient was kept in a darkened room and a modification of Stroganoff's drug and diet treatment was carried out, as in the above case :

Hours after fit.	Drug.	Fluids.
25 minutes	Calomel gr. v	—
50 ,,	Morphia gr. $\frac{1}{4}$ subcut.	—
2 hours	Chloral hydrate gr. xx *p.r.*	—
4 ,,	Morphia gr. $\frac{1}{6}$ subcut.	—
8 ,,	Chloral hydrate gr. xx *p.r.*	—
10 ,,	—	Water ʒiij.
12 ,,	—	Water ʒiij.
14 ,,	Chloral hydrate gr. xx *p.r.*	—
16 ,,	Mag. sulph. ʒij	Water ʒiv.
16½ ,,	—	Water ʒiv.
19 ,,	—	Water ʒiv.
22 ,,	Chloral hydrate gr. xx	Water ʒiv.

The patient's condition was now improving, but she was still kept in a darkened and quiet room. The children were not put to the breast for four days, but were fed on milk and water 1–3.

On the second and third days the patient had sensitized streptococcal vaccine (250 millions and 500 millons). The œdema gradually disappeared and her mental condition rapidly got much better, but the blood-pressure was still greatly raised.

Clinical Course.

During the next week the albumen content of the urine gradually diminished and the blood-pressure fell to 135/90 mm. Hg., and on discharge it was the same.

Day after fits.	B.P.	P.	T.	Urine.	Albumen.	B.O.	Mental state.
1st	215/180	64	99°	Not measured	0·4%	1	Bad.
2nd	215/185	72	98°	ʒxlv	0·2%	1	Slightly better.
3rd	195/165	64	98°	ʒxl +	0·3%	4	Much improved.
4th	215/180	72	98·2°	ʒxl +	0·32%	5	Normal.
5th	180/120	80	97°	ʒlxx	0·2%	2	,,
6th	210/130	72	98°	ʒlxxix	0·25%	2	,,
7th	210/130	64	98°	ʒlx +	0·42%	2	,,
9th	205/125	76	97°	Not measured	0·7%	4	,,
12th	195/110	92	98·4°	Do.	0·2%	1	,,
15th	150/100	96	98°	,,	0·1%	3	,,

The patient when seen one month later was still passing small quantities of albumen, but was quite healthy in all other respects. W. C. M.

STUDENTS' UNION.

RUGBY FOOTBALL CLUB.

SEASON 1926–27 PROSPECTS.

As a preliminary to discussing next season's prospects, let us examine last season's results. In figures these were :

	Played.	Won.	Lost.	Drawn.	Points for.	Points against.
1st XV	31	16	15	—	288	314
"A" XV	28	16	11	1	318	210

The three more junior teams won a comfortable majority of their matches. The above figures include the cup-ties, but give no indication of how these teams fared. The 1st XV were defeated in the semi-final round by the ultimate winners, while the " A " XV won the Junior Cup.

We want to improve on these results next year. We want to improve not only on the results, but also on the financial side of the Club affairs. As far as the latter is concerned, we only need more clement weather for our home matches. The fixture-list is practically the same as last year's.

Next year we have Vergette for our captain, and, on this ground alone, are justified in anticipating a successful season. Vergette should have no difficulty in collecting a very useful pack of forwards, since he will have several of last year's pack and most of the "A" XV forwards. If T. P. Williams and H. McGregor return, Vergette will have nothing to worry about at half-back, but it is by no means assured that we shall again have this excellent pair. Last year's three-quarters will be here, and we have no qualms about a full-back. As far as freshmen are concerned, we have heard of a three-quarter from Caius College, Cambridge, but it is early to speak of freshmen.

May we suggest that a " Fresher's " match be held in October on a Wednesday ? Such a match cannot be played before the season as few freshmen are here, but at the beginning of October it would certainly give the captain and other powers that be an opportunity of seeing the new men play.

In conclusion we hope that all the teams will enjoy good games, that the " A " will repeat last year's success, and that the 1st will not only enter the final, but win the Cup. P. G. LEVICK,

Hon. Treasurer.

REVIEWS.

WHAT'S BEST TO EAT? By S. HENNING BELFRAGE, M.D.(Lond.). With Practical Supplement by LUCY H. YATES, M.C.A. (William Heinemann [Medical Books], Ltd.) Price 7s. 6d.

This extremely hygienic book is intended for the layman rather than for the doctor, but there must be few doctors who would not gain some profit and entertainment from reading it. Its style is as bright as its cover is exotic, but, inside, it is all good sense.

The chapters on vitamins and on the dietetic treatment of constipation are particularly good. The facts are stated in "simple language" for the benefit of the layman, yet so cunningly as to inform without irritating the medical reader.

Dr. Belfrage has a fund of sound information to disburse on the subject of food, and he writes admirably. So many books devoted to diet produce a profound anorexia in the reader. This one triumphantly does not. A novel feature is the practical supplement, which consists of a series of cooking recipes compiled by Miss Lucy H. Yates. We do not feel qualified to criticize this, but the dishes look most attractive—in print.

PRACTICAL HISTOLOGY FOR MEDICAL STUDENTS. By D. T. HARRIS, M.B., B.S. (London: H. K. Lewis & Co., Ltd.) Price 7s. 6d.

This work is to be recommended to anybody who, *ab initio*, sets out to become a histological technician.

It is essentially practical, in that it gives clear and generally adequate information as to the commoner methods of hardening and staining tissues, and leaves out all reference to those obscure modifications which render larger works on this subject so terrifying to the beginner.

It seems to us that the author has confined himself a little too strictly to the technical side; once the student has prepared his slide he is left rather in the air. True, he is told categorically what he sees, but he is not always told what it looks like. It is difficult to convey an adequate impression of histological appearances without the use of coloured plates, and the author has allowed himself but one of these.

We like, however, his interpolation of alternate blank pages on which the student—if he can—is intended to draw his own diagrams.

The book is really a useful one, and goes far towards supplying a long-felt need.

MESENTERIC VASCULAR OCCLUSION. By A. J. COKKINIS, M.B., B.S.(Lond.), F.R.C.S.(Eng.). (London: Baillière, Tindall & Cox, 1926.) Pp. xii + 159. 5 Figs. Price 10s. 6d.

Many reasons have contributed to relegate the subject of thrombosis and embolus of the mesenteric vessels to a relatively obscure position in abdominal surgery. In support of his contention that the condition is not one of great rarity, the author quotes the figures of the London Hospital for the years 1918–25 of the cases of intestinal obstruction due to the less frequent causes, and in this series mesenteric occlusion occupies a more important position than either volvulus or chronic intussusception.

The earlier part of the book deals with an experimental investigation of the anatomy of the mesenteric circulation, and of the effects of ligature of various branches. The ætiological factors and pathological changes are discussed and a full account of 76 hitherto unpublished cases is given, together with their case-histories.

This book is a definite contribution to the subject of mesenteric vascular occlusion, and is to be recommended to the post-graduate student.

THE SURGERY OF GASTRO-DUODENAL ULCERATION. By Professor CHARLES A. PANNETT, M.D., F.R.C.S. (Humphrey Milford.) Pp. 154. Price 10s. 6d.

The literature of gastric and duodenal surgery is very crowded, but nevertheless there is room for Prof. Pannett's latest work. Indeed it is largely on account of the great wealth of the literature that a book giving a really clear, unbiased account of this great subject is so urgently needed; and here we have such a book.

The pathology, ætiology, symptomatology and treatment are fully discussed. Accounts of experimental work and statistical evidence are brought forth in a very concise and simple manner, without, as is so often the case, making the reading tedious.

There are separate chapters on perforation and hæmorrhage, also one on the technique of the several operations discussed in the previous chapters.

In this volume the senior student and the post-graduate will find all he wishes to know about the surgery of gastric and duodenal ulcers. The many difficulties, so often discussed, such as the relation of ulcer to carcinoma, the advisability of adding a gastro-enterostomy to the operation of simple suture for a perforation, and whether medical or surgical treatment is preferable for hæmorrhage from an ulcer, are stated in a very open and even manner.

We have not seen a book which gives such an excellent account of gastric and duodenal ulceration without the author being unduly biased towards particular theories or methods of treatment. Prof. Pannett is to be congratulated on this valuable and really useful addition to the literature.

SURGICAL OPERATIONS. By WILLIAM IBBOTSON, F.R.C.S.(Edin.). 2nd edition. (Faber and Gwyer.) Pp. 356. Price 6s. 6d.

To some the title "Surgical Operations" may be somewhat misleading, as this is in no sense a book on operative surgery.

The first part of the book—38 pages—deals with general considerations of surgical operations. The second part, the chief part of the book, contains a very complete list of all surgical operations with the names of the instruments required for each.

It is especially for nurses that this book is written, and for them it should be of some help in setting out the instruments for any operation. But in some cases nurses are likely to be confused rather than helped; for example in the three pages on prostatic operations, seven methods of prostatotomy, six for partial prostatectomy and three methods for complete prostatectomy are mentioned.

The last part of the book, which consists of pictures of many surgical instruments, both old and new, with their names, may be of some use to students in learning the names of instruments for their final examination.

HISTOLOGICAL TECHNIQUE. By H. M. CARLETON, M.A., B.Sc., D.Phil. (Humphry Milford, Oxford University Press.) Price 16s.

This book gives an admirable account of the details of histological technique. It can be said quite dogmatically that it is essential for every laboratory worker to have a copy. Not only does it represent the ripe experience of a skilled laboratory worker, crammed with practical details, but the arrangement of subjects has been made with great care, so that workers in all sections of histology will be satisfied. The cross-references are extremely good, the diagrams and print excellent. More detail might have been bestowed upon the section dealing with the preparation of stains, but on the whole the book amply serves the requirements of histologists. The book will undoubtedly become the standard reference for histological work, and the author is to be congratulated upon its publication.

PRACTICAL MICROSCOPY. By F. SHILLINGTON SCALES, M.A., M.D. (Baillière, Tindall & Cox.) Crown 8vo. Pp. 332. Price 8s. 6d.

Few medical students are acquainted with the theory of microscopy, and but a small proportion can obtain the maximum efficiency from a microscope. If any are inspired with a desire to further their knowledge, they may, with advantage, turn to this volume, for the elementary principles are stated in simple non-mathematical language—although with some of the more advanced aspects of the subject the absence of mathematical treatment renders the descriptions somewhat obscure. The print is good and the illustrations well chosen.

[In the review of Cameron's *Diseases of Children*, which appeared in our June issue, the price is quoted as 25s. net. It should be 5s. net.]

EXAMINATIONS, ETC.

UNIVERSITY OF OXFORD.

The following degree has been conferred:
B.M.—Bettington, R. H. B.

Final Examination for the Degrees of B.M., B.Ch., July, 1926.

Materia Medica.—Gilding, H. P.
Pathology.—Cuthbert, H. E., Harding, C. L., Kingsley, A. P.
Forensic Medicine and Public Health.—Clüver, P. F., Crisp, G. H., Cuthbert, H. E., Harding, C. L., Hudson, W. H., Kennedy, J. H.
Medicine, Surgery and Obstetrics.—Crisp, G. H., Cuthbert, H. E., Ford, J. N. C., Hamilton, K. A., Hudson, W. H., Kennedy, J. H., Savage, J. de la M., Tisdall, O. R.

UNIVERSITY OF LONDON.

First Examination for Medical Degrees, July, 1926.

Passed.—Bamford, H. C., Beard, A. J. W., Briggs, G. D. S., Cartwright, W. H., Churchill, M. H., Cunningham, G. J., Dean, D. M., Freeth, J. W. O., George, C. A., George, W. F. T., Hackett, L. J., Hargreaves, W. H., Hogg, W., Ishmael, D. T., Keane, C. A., Knight, B. W., McGladdery, W. F., O'Connell, J. E. A., Patrick, F. L. L., Petty, G. F., Ringdahl, K. E. O., Roberts, J. C., Staunton, A. A., Sugden, A., Taylor, J. T. C., Tidswell, T. H., Vaughan, H. B. D., Wright, P. M.

Second Examination for Medical Degrees, July, 1926.

Part I. Organic Chemistry.—Adams, F. P., Bochenek, S., Burgess, W. J., Coorland, H., Cunningham, G. J., Fawcett, R. E. M., Frankenberg, P., George, C. A., Hayes, D. S., Knight, B. W., Little, G. S. R., Ross, K. M., Tierney, T. F., West, J. H.
Part II. Anatomy, Physiology and Pharmacology.—Baker, E. F. D., Bennett, R. C., Burrows, W. R., Colville, J. R., Croft, D. F. L., Crumbie, J. R., Edwards, F. A., Evans, I., Harris, R. L. H., Hopton, J., Parsons, C. T. E., Pope, E. S., Price, R. K., Riley, A. C., Rogerson, H. L., Stark, H., Williams, J. O.

CONJOINT EXAMINING BOARD.

Pre-Medical, July, 1926.

Chemistry.—Andreasen, A. T., Cusack, M. K., Green, L. E., Jaensch, F. J., Roache, W. J., Ryan, T. J.
Physics.—Andreasen, A. T., Cusack, M. K., Green, L. E., Jaensch, F. J., Roache, W. J.

Second Examination, July, 1926.

Part. I. Anatomy and Physiology.—Burt, H. V.
Anatomy only.—Hopton, J.
Physiology only.—Mailer, W. A. R.
Part II. Pharmacology and Materia Medica.—Hind, H. G., Jones, O. T.

Final Examination, July, 1926.

The following have completed the examinations for the Diploma of M.R.C.S., L.R.C.P.:
Benton, W. F. D., Corfe, F. R., Crabtree, J. B., Cursetji, K. J., Darley, W. W., Davies, J. R. A., Day, C. A., de Souza, C. W. L., Foster, G. W. S., Greenwood, W. P., Hinton, W. S., Humphris, J. H., Jones, E. D., Melly, A. J. M., Paley, J. G., Posel, M. M., Row, A. W. L., Seymour-Isaacs, H. N., Smith, Surtees; Stokes, K. R., Wehlberg, T. H.

CHANGES OF ADDRESS.

ATKINSON, E. M., 16, Gay Street, Bath. (Tel. Bath 1846.)
BOSTOCK, A. H., Southfields, Chichester.
EVANS, E. LAMING, 33, Portland Place, W. 1. (Tel. Langham 2541.)
GILLON, G. GORE, 19, George Street, Ryde, Isle of Wight.
HERVEY, W. A., Hospital for Consumption, Brompton, S.W.
HODGE, B. L., Essex County Hospital, Colchester.
HUME, J. B., 41, Southway, N.W. 11. (Tel. Speedwell 5041.)
MOLONY, E. F., C.M.S. Men's Hospital, Ispahan, Persia.
PENTREATH, H. M., "The Nest," Denton, nr. Gravesend, Kent. (Tel. Gravesend 910.)
SCOTT, H. H., 20, Ridgmount Gardens, W.C. 1.
SCOTT, J. M. DUNCAN, Professor of Physiology, University of Saskatchewan, Saskatoon, Canada.
SMITH, W. C. B., Surg.-Comdr. R.N. (retired), "Bramcote," 2, Highfield Crescent, Southampton.
WALK, A., Horton Mental Hospital, Epsom, Surrey.

APPOINTMENTS.

DAVIES, J. H. T., M.B., B.Chir.(Cantab.), appointed Hon. Dermatologist to the Royal Alexandra Hospital for Sick Children, Brighton.
HERVEY, W. A., M.R.C.S., L.R.C.P., appointed House Physician to the Hospital for Consumption, Brompton, S.W.
HODGE, B. L., M.R.C.S., L.R.C.P., appointed House Physician to the Essex County Hospital, Colchester.

BIRTHS.

COOK.—On August 11th, at "Marven," Uplyme, Lyme Regis, to Mona (*née* Schofield), wife of Dr. P. N. Cook—a daughter.
LAUDER.—On August 2nd, the wife of Dr. Harold V. Lauder, of 80, Southampton Street, Reading—a daughter (Iris Anna Lynn).
LYDIARD WILSON.—On July 29th, to Dr. and Mrs. H. Lydiard Wilson, of 3, Gordon Square—a son.
SHORE.—On July 31st, at 28c, Devonshire Street, W., to Janet, the wife of Dr. T. H. Gostwyck Shore—a daughter.
WELLS.—On July 23rd, at 16, Bruton Street, W., to Rhona, wife of Dr. Arthur Quinton Wells, of Eyam, Derbyshire—a son.

MARRIAGE.

BEITH—PELL.—On August 7th, at All Saints', Leicester, by the Rev. A. G. Blackmore, M.A., Dr. Andrew Edwin, fourth son of the late George Beith, Fairlawn, Pontypridd, and Mrs. Beith, Tregenna, Porthcawl, to Rose Bigot, elder daughter of Dr. and Mrs. William Pell, Leicester.

DEATHS.

BARRON.—On August 14th, 1926, suddenly, at the Glasgow Royal Infirmary, Colonel T. Ashby Barron, D.S.O., T.D., of Spondon, Derbyshire.
GIMSON.—On August 10th, 1926, at Witham, Essex, Karl Carwardine Gimson, M.B.(Cantab.), aged 59.
HUNTLEY.—On August 1st, at a nursing home, Folkestone, James Huntley (Bart.'s student), youngest son of Mr. and Mrs. M. Huntley, in his 22nd year.
HUTT.—On February 24th, 1926, at Tua Kau, Auckland, New Zealand, Herbert Augustus Hutt, M.R.C.S., L.R.C.P.
ROGERS.—On August 7th, 1926, at Matlock, Braithwaite Rogers, M.D.(St.And.), M.R.C.S., L.S.A., late of Upper Westbourne Terrace, London, and Lamplugh, Cockermouth, aged 92 years.
SEYMOUR.—On July 24th, 1926, at Debourne, Cowes, I.W., Edgar William Seymour, M.V.O., M.B.(Cantab.), only son of the late Dr. William Hoffmeister, of Cowes.
WALKER.—On July 16th, 1926, George Walker, M.D.(Brux.), of Upper Norwood.

NOTICE.

All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, *St. Bartholomew's Hospital, Smithfield, E.C. 1.*

The Annual Subscription to the Journal is 7s. 6d., including postage. Subscriptions should be sent to the MANAGER, W. E. SARGANT, M.R.C.S., *at the Hospital.*

All Communications, financial or otherwise, relative to Advertisements ONLY should be addressed to ADVERTISEMENT MANAGER, *The Journal Office, St. Bartholomew's Hospital, E. C. Telephone: City 510.*